IN THE MATTER OF	*	**BEFORE THE MARYLAND**
CATHERINE ~~COEHLO~~ Coelho, P.T.	*	**STATE BOARD OF**
RESPONDENT	*	**PHYSICAL THERAPY**
LICENSE NUMBER: 20246	*	**CASE NUMBER: 09-55**

* * * * * * * * * * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

On or about July 13, 2011, the Maryland Board of Physical Therapy Examiners (the "Board"), charged Catherine Coehlo, P.T. (the "Respondent") (D.O.B.: 4/27/75), **License Number 20246** with violations of certain provisions of the Maryland Physical Therapy Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 13-101 *et seq.* (2009 Repl. Vol. and 2010 Supp.).

Specifically the Board charged the Respondent with the following provisions under § 13-316 of the Act:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a license or restricted license if the applicant, licensee, or holder:
>
> > (4) In the case of an individual who is authorized to practice physical therapy is grossly negligent:
> >
> > (i)In the practice of physical therapy;
> >
> > (15) Violates any provisions of this title or rule or regulation Adopted by the Board;
> >
> > (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy; and

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	•	
	•	

[illegible]

[illegible]

[illegible]

[illegible]

[

(25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy[.]

The pertinent provisions of the Code of Maryland Regulations ("COMAR") referred to, *infra*, in §13-316(15) provide the following:

COMAR 10.38.03.02 **Standards of Practice.**

§ A(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;

(b) Provide:

(ii) Each patient with adequate treatment time consistent with accepted standards in delivering physical therapy care;

(e) Evaluate the patient and develop a plan of care before the patient is treated; and

(g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not reevaluating the patient[.]

COMAR 10.38.03.02-1 **Requirements for Documentation.**

§A The physical therapist shall document legibly the patient's chart each time that patient is seen for:

(2) Subsequent visits, including the following information (progress notes):

(f) Changes in plan of care[.]

(3) Reevaluation, by including the following information in the report which may be in combination with the visit note, if treated during the same visit:

(c) Reevaluation, tests, and measurements of areas of body treated;

(d) Changes from previous objective findings;

(e) Interpretation of results;

(f) Goals met or not met and reasons;

(g) Updated goals; and

(h) Updated plan of care including recommendations for follow up[.]

FINDINGS OF FACT

The Board finds the following:

I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is a physical therapist, licensed to practice in the State of Maryland. The Respondent was initially licensed in Maryland on July 12, 2001. The Respondent's license expires on May 31, 2012.

2. At all times relevant hereto, the Respondent was engaged in the practice of physical therapy and employed by a physical therapy and sports medicine treatment facility ("Facility A")[1] in Chevy Chase, MD.

II. THE COMPLAINT

3. On or about December 15, 2008, the Board received information from the Health Care Alternative Dispute Resolution Office regarding a civil claim against the Respondent. The claim, filed by a former patient of the Respondent alleged, among other things, that the Respondent was negligent in her treatment and care of an eighty-six (86) year old patient ("Patient A") and that her negligence caused or contributed to Patient A suffering a cervical dislocation and fracture.

4. The civil claim[2] also alleged that the Respondent[3] breached the appropriate standard of care of a reasonably competent physical therapist by:

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[1] Facility names are not used in this document in order to preserve confidentiality.
[2] The allegations set forth in the civil claim have been abridged and/or paraphrased and do not purport to be direct quotes.
[3] The Respondent was not the only named defendant in the civil claim.

(a) failing to timely and properly assess Patient A's overall physical condition at the beginning of each of the physical therapy sessions;

(b) failing to develop an appropriate management plan for the proper treatment of Patient A during his physical therapy sessions;

(c) failing to consult with Patient A's physicians with regards to Patient A's cardiac history and history of hypotension;

(d) failing to verify that Patient A had received appropriate authorization from his cardiologist, to engage in physical therapy treatment;

(e) failing to implement strategies to prevent patient injury during physical therapy sessions; and

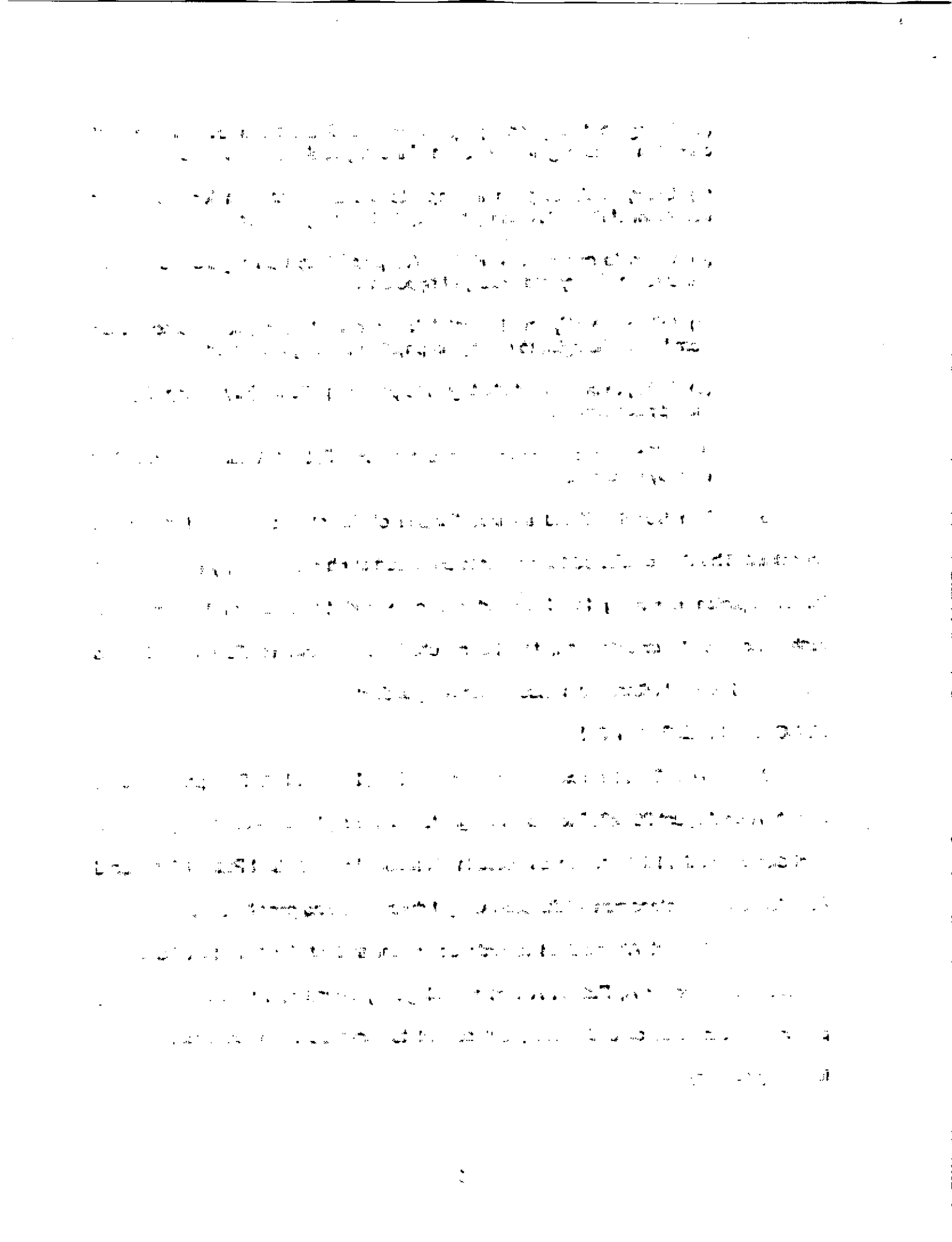
(f) failing to properly monitor and supervise Patient A during the physical therapy sessions.

5. The Board initiated an investigation of the allegations set forth in the complaint. The Board referred the matter to an expert in physical therapy ("the Expert") for an opinion regarding the Respondent's care and treatment of Patient A. In furtherance of its investigation, the Board obtained relevant medical records and interviewed several witnesses, including the Respondent.

III. BOARD INVESTIGATION

6. The Board's investigation revealed that Patient A first presented to Facility A on August 20, 2005 following a right total knee replacement and degenerative joint disease of the left knee. It was noted in his medical records that Patient A suffered from "posterior displacement of the body weight during gait and poor balance."

7. Patient A's medical records document that at the time that he began treatment at Facility A, Patient A was neurologically sound and was independently performing activities of daily living, but sought to increase his rehabilitative efforts following surgery.



8. Beginning in August 2005 through November 2007, Patient A received physical therapy at Facility A several times per week. The physical therapy included measurement and fitting of orthotics, manual therapy, and various therapeutic exercises. The Respondent was a supervising physical therapist employed by Facility A, who provided treatment and care to Patient A on approximately 48 occasions.

9. On or about May 10, 2007, Patient A alerted another physical therapist at Facility A ("Therapist 1") that he was scheduled to receive an artificial cardiac pacemaker.[4] Therapist 1 noted in Patient A's chart that before resuming treatment, Patient A would need clearance from his cardiologist prior to returning to his physical therapy regimen.

10. On or about June 21, 2007, Patient A advised he was cleared for physical therapy, which was resumed at that time without documented medical clearance from his physician.

11. On or about June 28, 2007, Patient A reported to the Respondent that he had been experiencing problems with his pacemaker, and that his physician was attempting to adjust his cardiac medication. Complications following placement of a pacemaker and side effects from cardiac medication were significant medical complaints, yet the Respondent failed to formally reevaluate Patient A at that time, despite a clear change in his medical status. The Expert retained by the Board, opined that the standard of practice requires that a patient be formally reevaluated if his medical status changes or at least every thirty (30) days. In Patient A's case, there had been both a lapse of thirty (30) days and a change in his medical status.

[4] An artificial cardiac pacemaker is a medical device that uses electrical impulses to maintain an adequate heart beat.

12. In addition, Patient A's medical complaints placed the Respondent on notice that Patient A had a serious cardiac condition requiring not only medication but also placement of a pacemaker.

13. Although the Respondent knew or should have known that Therapist 1 as well as other health care providers were treating Patient A and had knowledge of his clinical history, she failed to communicate with either Therapist 1 or the other health care providers to ascertain whether Patient A could safely continue physical therapy

14. On or about August 28, 2007, Patient A reported to the Respondent that his physician had informed him that he was "overmedicated" regarding the management of his hypotension[5]. The Respondent failed to take any action following this reported complaint.

15. On or about October 2, 2007 Patient A reported to the Respondent that he had experienced "dizzy spells" that he believed were the result of his hypotension treatment. The Respondent failed to take any action following this reported complaint.

16. The standard of care required that the Respondent, upon learning of Patient A's continued medical/cardiac complaints and treatment, take appropriate action, including but not limited to:

a. communication and/or coordination of care with Therapist 1;

b. consultation with Patient A's treating cardiologist/health care providers;

c. reevaluation of Patient A based upon reported changes in medical status and/or the passage of thirty (30) days; and

d. modification of Patient A's treatment plan and/or goals.

[5] Hypotension is commonly referred to as low blood pressure.

17. On November 1, 2007, Patient A arrived at Facility A for a physical therapy session with the Respondent. During her interview with Board staff the Respondent stated that Patient A checked in with her in the staff office. She directed Patient A to begin physical therapy on the Shuttle[6] machine ("the Shuttle") while she completed paperwork for another patient.

18. The Respondent admitted that at the time of Patient A's fall, she was not visible to him nor was he visible to her. The Respondent stated that she expected Patient A to independently secure himself on the Shuttle, to adjust the resistance bands himself and to disembark without assistance. She stated that this expectation was based upon his prior use of the Shuttle.

19. The Respondent stated during her interview with Board staff she was completing treatment with another patient at the same time that Patient A was directed to begin physical therapy on the Shuttle. She explained that Facility A... "[was] really set up in a way where patients—I mean, really need to be fairly independent to be here...." She stated that unless Facility A received a note from a physician requesting constant supervision, the Respondent typically allowed patients to complete exercises without assistance or supervision. Upon completion of the exercise(s), the patient typically reported to the Respondent that they were finished and the Respondent noted their completion on an exercise flow chart.

20. Conflicting versions as to how Patient A fell are contained within the record. Based on the Board's investigation, it is believed that Patient A attempted to secure himself on the Shuttle machine but discovered that the resistance bands were

[6] During her July 22, 2009 interview with the Board, the Respondent described the Shuttle machine as a type of a leg press with bands that provide variable amounts of resistance.

7. On November 1, 2007 [illegible] A [illegible]

[illegible] Respondent [illegible]

8. [illegible]

9. The Respondent [illegible]

10. [illegible]

[illegible]

not properly adjusted for his particular exercise regimen[7]. Patient A attempted to get off the machine, unassisted, to adjust the bands. While he was doing so, he fell, striking the ground. The Respondent heard a loud noise and exited the staff office, at which time she discovered that Patient A had fallen.

21. Patient A was transported by ambulance to the emergency room of the nearest hospital ("Hospital A") where he was diagnosed with a cervical fracture and dislocation. He remained a patient at Hospital A for thirteen (13) days during which time he underwent surgery to repair his cervical fracture.

22. Following his discharge from Hospital A, Patient A received rehabilitative and sub-acute nursing care. He subsequently developed neck pain and left side weakness. He sought a consultation from health care providers at another local hospital ("Hospital B"), who recommended that Patient A undergo another surgical procedure ("Surgery 2") on his cervical spine in order to alleviate his pain.

23. On or about February 5, 2008, Patient A was admitted to Hospital B to undergo Surgery 2. He remained at Hospital B until February 25, 2008. At that time, he was discharged and once again received rehabilitative and sub-acute nursing care.

24. Following Surgery 2, Patient A experienced numerous complications, resulting in a myriad of medical procedures, including but not limited to, the placement of a gastronomy tube for nutrition, an indwelling urinary catheter, and treatment for the development of bedsores.

25. Since his discharge from Hospital B, Patient A has required home nursing care and assistance with daily living due to his neurological and physical deficits. Prior

[7] In her interview with Board staff, the Respondent stated that it was noted in Patient A's chart that he use five (5) bands of resistance utilizing both legs and four (4) bands of resistance when utilizing only one leg.

to the unsupervised fall at Facility A, Patient A was neurologically sound, and independent in his daily activities of living.

26. The Board's Expert concluded, among other things, that the Respondent violated the Act, through her failure to meet the acceptable standard of care in the delivery of physical therapy, in the following ways:

a. failed to document a treatment plan, including objective findings justifying continued physical therapy treatment;

b. failed to properly assess and/or document Patient A's clinical progress, increase in mobility or potential to benefit from continued physical therapy treatment;

c. failed to maintain adequate progress notes, including treatment modalities, date and signature;

d. failed to confirm medical clearance following placement of the pacemaker;

e. failed to communicate and/or document communication between she and other treating health care providers;

f. failed to reevaluate the patient;

g. failed to monitor vital signs; and

i. failed to adequately supervise Patient A during physical therapy treatment.

27. Respondent retained experts, through counsel, in connection with the underlying civil litigation and those experts issued reports opining that the Respondent complied with applicable standards. Those expert reports, along with additional documentation and deposition testimony were submitted to the Board for its consideration.

28. On or about September 20, 2011, the Respondent, her attorney and the Administrative Prosecutor on behalf of the State, appeared before the Case Resolution

Conference Committee (the "CRC") of the Board. As a result of negotiations and consideration of the documents submitted, the Respondent, the Board and the State agreed to enter into this Consent Order. A quorum of the Board accepted the negotiated settlement on or about October 18, 2011.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated H.O. §13-316(15) and (25) and COMAR 10.38.03.02(A)(2)(a),(e),(g) and 10.38.03.02-1(A)(2),(f), and (3)(c),(d),(e),(f),(g), and (h). The Board dismisses the charges under H.O. § 13-316, (4)(i) and (19).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 20th day of December 2011, by a majority of the Board considering this case:

ORDERED that the Respondent's license to practice physical therapy is hereby **REPRIMANDED**; and it is further

ORDERED that the Respondent's license to practice physical therapy shall be placed on **PROBATION** for a period of **ONE (1) YEAR,** to commence from the date that this Consent Order is executed, and be it further

ORDERED that within one (1) year of the date of the Consent Order, the Respondent shall enroll in and successfully complete a Board-approved course in documentation; and be it further

ORDERED that the Continuing Education requirements required by this Consent Order shall not count toward fulfilling other continuing education requirements that the Respondent must fulfill in order to renew her license to practice physical therapy; and be it further

ORDERED that Respondent shall comply with the Maryland Physical Therapy Act and all laws, statutes and regulations pertaining to the practice of physical therapy; and be it further

ORDERED that if Respondent violates any of the terms and conditions of this probation and/or this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or after an opportunity for a show cause hearing before the Board, may impose any sanction which the Board may have imposed in this case under the Maryland Physical Therapy Act, including a reprimand, probation, suspension, revocation and/or a monetary fine, said violation being proved by a preponderance of the evidence; and be it further

ORDERED that at the conclusion of the one (1) year probationary period and only after the Board's receipt of documentation confirming successful completion of the probationary conditions, the Respondent may petition the Board for termination of probation; and be ir further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 et seq. (2009 Repl. Vol. and 2011 Supp.).

12/20/11
Date

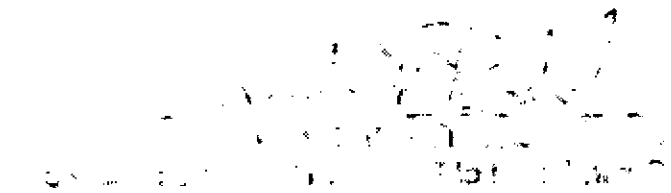
John Baker, P.T., D.S.C.P.T.
Chair, Board of Physical Therapy Examiners

CONSENT OF CATHERINE ~~COEHLO~~ Coelho, P.T.

I, Catherine ~~Coehlo~~ Coelho, P.T., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by the foregoing Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce the Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.



12/1/2011
Date

Catherine ~~Coehlo~~ Coelho, P.T. 12/1/11

Read and approved by:

John J. Murphy, Esq., Attorney for the Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Rockville: Montgomery County:

I HEREBY CERTIFY that on this 1st day of December, 2011, before me, a Notary Public of the foregoing State personally appeared Catherine Coehlo, P.T. License Number PT20246, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Notary Public

My Commission Expires: 4/3/2012

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF MARYLAND
TUMELO NAANYANE-NTESO
PRINCE GEORGE'S COUNTY
MY COMMISSION EXPIRES 4/3/2012